

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038984

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

1295

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

• AMENDED

FILED NOV 13 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Caldwell	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph,		c. CITY OR TOWN Hamilton,	
Length of stay in 1b 21 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) State Hospital #2		d. STREET ADDRESS (If outside, give location) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH WINSOR DOLMAN			4. DATE OF DEATH Month Day Year November 9, 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1872	9. AGE (last birthday) 91	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coffee Roaster		10b. KIND OF BUSINESS OR INDUSTRY Coffee Roasting		11. BIRTHPLACE (City and state or country) Caldwell County, Mo. U.S.A.	
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME John F. C. Dolman			
13b. MOTHER'S MAIDEN NAME Mattie E. Green		14. NAME OF HUSBAND OR WIFE Gertrude Dolman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [Redacted]		17. INFORMANT State Hospital #2 Records, St. Joseph, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Ca 2 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Fracture of right ankle dehydration; arteriosclerotic heart disease</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from <i>Oct 18, 1963</i> and last saw her alive on <i>Nov 7, 1963</i> Death occurred at <i>1:25</i> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>W. B. Pettit M.D.</i> (Degree or title)	22b. ADDRESS State Hospital, St. Joseph, Mo.	22c. DATE SIGNED 11-9-1963
--	---	-------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 9, 1963	23c. NAME OF CEMETERY OR CREMATORY Bram Funeral Home	23d. LOCATION (City, town, or county) Hamilton, Missouri
---	---------------------------	---	---

24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Nov. 12, 1963	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Goodell</i>
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

M.B. Pettit, M.D. MEDICAL CERTIFICATION

VS 300
Rev. 4/59
1 5117
2 0130
3
4 10
5 1
6
7 0
8 2
9 1-9
10 6
11
12 93-0
13 1-0

NOV 27 1963

Permit issued 11-10-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Albert A. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.